GROUP MEDICAL CLAIM FORM

HealthComp
Third Party Administrators

SUBMIT CLAIMS TO: P.O. BOX 45018, FRESNO, CA (800) 442-7247

1. Your Policy and/or Group number(s)

2. Name and address of employer

EMPLOYEE INFORMATION

3. Name of employee *(insured)* | ☐ Male ☐ Female | **Date of Birth** | ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

4. Address of employee Street City State Zip Code

5. Employee's Social Security number

6. Name of Spouse | **Spouse's Date of Birth** | **Spouse's Social Security number**

7. (a) Are you or any member of your family covered under Medicare? ☐ Yes ☐ No
(b) Are you or any member of your family covered under another Group Plan providing medical benefits? ☐ Yes ☐ No

REMARKS:
If you have checked Yes to any of the above, please provide policy number _____
Effective date _____
Name of insured _____
Name and address of insurance company _____
_____
Name and address of the employer, *(school, union)* or organization which sponsors the coverage _____
_____

If you are covered by Medicare, or any other basic hospitalization or surgical plan such as Blue Cross-Blue Shield, please submit these carrier's payment statements or declinations along with itemized bills.

COMPLETE FOR INJURY OR ILLNESS

8. This claim is for ☐ Employee ☐ Spouse ☐ Child

9. This claim is for ☐ ILLNESS

Give Time And Date. Briefly Describe How Injury Occurred.

☐ ACCIDENT ON

Does this claim involve a work-related illness or injury? ☐ Yes ☐ No

IF CLAIM FOR DEPENDENT, COMPLETE THIS SECTION ALSO

10. Name of your dependent | ☐ Male ☐ Female | **Date of Birth** | **Social Security number if dependent child 18 or over**

11. Is dependent employed? ☐ Yes ☐ No
Is dependent a full-time student? ☐ Yes ☐ No
Name and phone number of dependent's employer or school

12. Address of employer or school Street City State Zip Code

IMPORTANT – PLEASE COMPLETE AUTHORIZATION SECTION

13. AUTHORIZATION TO RELEASE INFORMATION:

The above answers are true and correct to the best of my knowledge. I hereby authorized any physician, surgeon, practitioner or other person, any hospital, including veterans administration or government hospital, any medical service organization, any insurance company, or any other institution or organization to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A Photostat of this authorization shall be as valid as the original.

Signed (Patient or Parent if Minor) **Date**

14. AUTHORIZATION TO PAY INSURANCE BENEFITS:

I hereby authorize payment directly to the Physician named above those benefits otherwise payable to me but not to exceed the Physician's regular charges. I understand I am financially responsible to the Physician for charges not covered by this authorization.

Signed (Patient or Parent if Minor) **Date**

Please attach itemized bills to this form and mail to : HEALTHCOMP, INC.